

Early Assessment and Support Team (EAST): Guidelines for Referral

The following are guidelines to decide whom to refer to EAST. Clients that are a good fit for EAST have symptoms of psychosis consistent with schizophrenia related conditions. Acceptance into the program will be based on further screening and assessment. Referents should explain to individuals that they are being referred for an assessment to determine whether EAST is a good fit for them and should continue to follow up with individuals referred until a decision regarding EAST is made.

Must meet all of the following:

- ___ 1. Resides in Linn, Marion, Polk, Yamhill or Tillamook Counties.
- ___ 2. Age 12-25
- ___ 3. The person has an IQ of 70 or above and does not have a previous diagnosis of a pervasive developmental disorder (e.g. Autism, Aspergers).
- ___ 4. The person has not received treatment for a psychotic illness prior to the last 12 months.
- ___ 5. Psychotic symptoms are not known to be caused by the temporary or chronic effects of substance abuse or a known medical condition.
- ___ 6. The person has experienced a significant decline in either academic, vocational, social or personal (sleep, hygiene) functioning.

And must meet *either 7 or 8* below:

- ___ 7. The individual has experienced significant worsening or new symptoms in one or more of the following areas *in the last 12 months*:
 - a. Thought disorganization as evidenced by disorganized speech and or/ writing. (Examples: confused conversations, not making sense, never getting to a point, unintelligible).
 - b. Behaviors, speech or beliefs are uncharacteristic and/or bizarre.
 - c. Complains of hearing voices or sounds that others do not hear.
 - d. The individual feels that other people are putting thoughts in their head, stealing their thoughts, believes others can read their mind (or vice versa), and/or hear their own thoughts out loud.
 - e. Episodes of depersonalization (Example: They believe that they do not exist or that their surroundings are not real).
 - f. Heightened sensitivities (lights, sounds etc.) and/or is experiencing visual distortions
 - g. Increased fear, anxiety or paranoia for no apparent reason or for an unfounded reason.

OR

- ___ 8. Family history of a 1st degree relative (sibling or parent) with a major psychotic disorder.

If the individual you are referring is in *an immediate danger to self or others you will need to refer directly to the local crisis system*. The crisis system will refer to EAST when the crisis resolves.

To make a referral call or fax a referral form to the EAST Team Lead in the individual's county of residence. Include with your fax all relevant assessments and releases of information.

Marion: 503-576-4690 Fax: 503-584-4837

Yamhill: 503-588-5527 or 503-434-7523 ext 4731. Fax: 503-434-9846

Polk: 503-385-7417 or 503-623-1886 ext. 213. Fax: 503-623-7560

Tillamook: 503-812-8460 or 503-842-8201 ext. 245 Fax: 503-815-1870

Linn: 541-967-3866 ext. 2503 Fax: 541-926-6271.

For general program inquiries, call Ryan Melton, EAST Clinical Supervisor, at 503-361-2667 or 1-888-327-8817.

EAST PROGRAM - REFERRAL FORM

County of Residence: _____

Initials of Individual being referred: _____

Individual being referred: First Name: _____ Last Name: _____

Phone: _____ Fax: _____

Address: _____ E-mail: _____

Referral Date: _____

Individual's Demographic

Ethnicity : (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> White (Non-Hispanic) | <input type="checkbox"/> Asian | <input type="checkbox"/> Other Hispanic |
| <input type="checkbox"/> Black/African American (Non-Hispanic) | <input type="checkbox"/> Hispanic (Mexican) | <input type="checkbox"/> Southeast Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Hispanic (Puerto Rican) | <input type="checkbox"/> Other Race / Ethnicity |
| <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Hispanic (Cuban) | <input type="checkbox"/> Hawaiian / Other Pacific Islander |

Primary Language: English / Spanish / Other _____

Gender: M / F **Date of Birth:** _____

How was the client/family referred? Check only ONE. (Individual who called in the referral or encouraged family or individual to call.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Crisis System / Emergency Department | <input type="checkbox"/> Social Services Provider | <input type="checkbox"/> Public presentation |
| <input type="checkbox"/> Outpatient Mental Health Provider | <input type="checkbox"/> Law Enforcement / Corrections | <input type="checkbox"/> Media |
| <input type="checkbox"/> Psychiatric Hospital | <input type="checkbox"/> Word of mouth from community / People Treated by the program | <input type="checkbox"/> Website |
| <input type="checkbox"/> Medical Provider | <input type="checkbox"/> Local advocacy group | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> School | | |

Referent Contact Information: *(Person making the referral)*

First Name: _____ Last Name: _____

Phone: _____ Fax: _____

Address: _____ E-mail: _____

Relationship to Individual being referred: _____ (family member, counselor, teacher, ect...)

How long have you known the person you are referring:

<input type="checkbox"/> Less than 1 month	<input type="checkbox"/> 1 - 2 years
<input type="checkbox"/> 1 - 6 months	<input type="checkbox"/> 3 - 5 years
<input type="checkbox"/> 6 - 12 months	<input type="checkbox"/> More than 5 years

Who should EAST contact regarding engaging the individual in screening: _____

First Name: _____ Last Name: _____

Phone: _____ Fax: _____

Address: _____ E-mail: _____

Legal Guardian: *(If appropriate)*

First Name: _____ Last Name: _____

Phone: _____ Fax: _____

Address: _____ E-mail: _____

EAST PROGRAM - REFERRAL FORM

County of Residence: _____

Initials of Individual being referred: _____

List of additional Contacts: (Family, Guardians, Tx Providers, and Supports)

Name	Relationship	Mailing Address	Phone #	Language

Reason for Referral (include description of specific symptoms, onset, frequency, severity, and duration):

Is the person being referred Bi-Lingual ? YES / NO

Relevant cultural issues, beliefs or practices (from another country/culture, acculturation, religious, social concerns

Person's knowledge about / reaction to referral: _____

Other services received prior to referral ? YES / NO List if known

Living Situation at Referral:	<input type="checkbox"/> Family	<input type="checkbox"/> Spouse	<input type="checkbox"/> Homeless
	<input type="checkbox"/> Alone	<input type="checkbox"/> Foster Parents	<input type="checkbox"/> Hospital
	<input type="checkbox"/> Roommates	<input type="checkbox"/> Dorm	<input type="checkbox"/> Residential Program
	<input type="checkbox"/> Friend	<input type="checkbox"/> Group Home	<input type="checkbox"/> Juvenile Detention
<input type="checkbox"/> Other : Please list _____			

Educational involvement at Referral:		
<input type="checkbox"/> Not in school - Wants to go to school	<input type="checkbox"/> Part-time school	<input type="checkbox"/> Full-time school
<input type="checkbox"/> Not in school - Does not want to go to school	<input type="checkbox"/> Part-time Trade School	<input type="checkbox"/> Full-time Trade School
<input type="checkbox"/> Not in school - Pre-educational exploration	<input type="checkbox"/> Part-time GED	<input type="checkbox"/> Completed Schooling
Last grade completed: _____ <i>(count each year of post-high school as a grade)</i>		

EAST PROGRAM - REFERRAL FORM

County of Residence: _____

Initials of Individual being referred: _____

Employment at Referral: <input type="checkbox"/> Not working - Does not want to work <input type="checkbox"/> Not working - Wants to work <input type="checkbox"/> Not working - Took specific steps toward working	<input type="checkbox"/> Working Part-time <input type="checkbox"/> Working Full-time <input type="checkbox"/> Not Working Age	Employment Type at Referral: <input type="checkbox"/> Competitive <input type="checkbox"/> Sheltered <input type="checkbox"/> Volunteer
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Insurance Status at admit (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> OHP <input type="checkbox"/> MEDICARE <input type="checkbox"/> Private: _____ <div style="text-align: right; margin-top: 5px;">Name of Insurance Company</div>
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Referent Information

Information about person making referral: The information below is voluntary and won't affect the outcome of this referral. We use the information to improve our outreach efforts.

Is this your first referral to EAST? YES / NO

How did you hear about EAST? : <input type="checkbox"/> Crisis System/Emergency <input type="checkbox"/> Department <input type="checkbox"/> Outpatient Mental Health provider <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Medical Provider <input type="checkbox"/> School	<input type="checkbox"/> Social Services Provider <input type="checkbox"/> Law Enforcement/ Corrections <input type="checkbox"/> Word of mouth from community /People treated by EAST <input type="checkbox"/> Local advocacy group <input type="checkbox"/> Public Presentation	<input type="checkbox"/> Media <input type="checkbox"/> Website <input type="checkbox"/> Other: Please list: _____
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25. Please check the category that best describes yourself.		
<input type="checkbox"/> (1) School professional <input type="checkbox"/> (2) College Resident Assistant <input type="checkbox"/> (3) Medical Professional <input type="checkbox"/> (4) Mental Health Professional <input type="checkbox"/> (5) Substance Abuse Counselor <input type="checkbox"/> (6) Youth Worker	<input type="checkbox"/> (7) Multicultural leader <input type="checkbox"/> (8) Member of Clergy <input type="checkbox"/> (9) Member of the Media <input type="checkbox"/> (10) Employer <input type="checkbox"/> (11) Parent <input type="checkbox"/> (12) Member of Community Group	<input type="checkbox"/> (13) Law Enforcement Professional <input type="checkbox"/> (14) Middle School Student <input type="checkbox"/> (15) High School Student <input type="checkbox"/> (16) College Student <input type="checkbox"/> (17) Young Adult (18-25)



Frequently Asked Questions for Referents

For information on EAST's services and who to contact to refer please go to our website:

www.eastcommunity.org, for information on the EASA programs visit <http://www.oregon.gov/DHS/mentalhealth/services/easa/main.shtml>.

You may also call 1-888-327-8817.

What happens when I make a referral?

The EAST Team Lead for the individual's county of residence will collect more information from you about the person's symptoms, history and situation. At that point, the Team Lead may want to complete an initial assessment with the individual and/or family. EAST attempts to make sure that people are receiving the most appropriate treatment by doing a careful upfront screening and initial differential diagnosis process. EAST asks that if you are currently working with someone who is referred to EAST, you maintain your involvement until EAST has formally accepted the person into ongoing services. If it is determined that EAST is not a good fit for the individual, we will support the individual, family and/or referent to identify resources that are more likely to be helpful.

When might EAST not accept someone who seems to fit the referral guidelines?

EAST is a specialty program focusing on individuals whose symptoms are consistent with the early stages of schizophrenia related conditions. A number of other conditions, such as ADHD, major depression, severe anxiety, or post-traumatic stress disorder can have symptoms similar to the early stages of psychotic illness, but require a different form of treatment and support. EAST tries to ensure that the clinical services the person receives are appropriate to that person, and will not accept individuals whose treatment needs are different than EAST's primary focus.

How can I help make the referral go more smoothly?

It is not uncommon that the EAST Team Lead will want to review medical and /or mental health documentation regarding the client's symptoms and current status. If you have access to such documentation, providing that to EAST directly with signed releases of information will move the process along more quickly. It is not necessary to have such documentation to make a referral, though it is important to fill out the referral form as completely as possible.

Does EAST accept people who are actively using illegal drugs?

EAST recognizes that young people with the conditions we serve use illegal drugs and will not be automatically screened out as a result. However, if as part of the initial screening process, EAST learns that the drug use is the primary contributor to the current symptoms, the individual will be screened out and referred to appropriate services.

Does EAST ever accept individuals over the age of 25 or under the age of 12?

Yes, EAST will consider accepting individuals into the program outside our age criteria if it is determined in the screening that all other criteria are met. However EAST's focus is on serving the developmental needs of a group in the transitional age range. To meet the needs of our current clients EAST will not accept individuals significantly outside of our age criteria.

Does EAST ever accept individuals who live outside the counties of Marion, Polk, Yamhill, Linn or Tillamook?

No, we are restricted to this geographic area. However, if the individual lives in a county where an EASA program ("Early Assessment and Support Alliance" program—newer programs modeled after EAST) is operating, we will facilitate a referral to them.

What if the person I want to refer is appropriate for EAST but does not want help?

EAST can be very flexible in working with the individual's support system to provide them with information and strategies for engaging the individual. EAST can also meet the client in an environment that is comfortable for them and engage them in a way that is not focused on mental health treatment.

Will EAST accept people who are acutely psychotic?

Yes, however if EAST feels the individual is at risk of harming oneself or others we may ask and/or assist in the individual receiving hospital care. If the client is appropriate for services we will stay involved with the individual and the family throughout this episode.

Will EAST accept people who have been ill for longer than 12 months?

We recognize that it can take years for a serious mental illness to be diagnosed, and will accept individuals who have had a lengthy "prodromal period" prior to coming to the attention of mental health professionals. However, if an individual carries a diagnosis of a schizophrenia related illness for more than a year, they are not appropriate for EAST.

Will EAST accept someone who is developmentally delayed/disabled and psychotic?

No, as this individual would have special needs beyond EAST's treatment parameters, and would be better served by the DD system.

What does it cost to be served by EAST? Does EAST take insurance?

EAST will bill insurance, whether OHP or private, for all applicable services. Much of what EAST provides is not covered by insurance; therefore, EAST also has a sliding fee scale we will review with you prior to consent for treatment. Our mission is to serve eligible individuals regardless of ability to pay, though we would ask people to do their best to pay for services rendered so that EAST can sustain its services into the future.

How long does it take someone to be accepted into EAST?

Once a referral form is received, the Team Lead will typically contact the referent within two business days to begin the screening process. From there, the process can take anywhere from 1 day to several weeks depending on the information available, the acuity of the individual and the availability of the individual and their support system. EAST will keep the referent informed of their progress throughout the screening process. You will be notified directly when the client is accepted. If the client is screened out, you will be notified by phone and/or letter. The letter will describe reasons why the person was not a good fit for EAST and recommend other resources.